



Camino de Salud Network

Redefining Managed Care for the Safety Net

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Modern Healthcare



Situation

- High utilizers of emergent and inpatient services
- Chronically ill patients not receiving ongoing care
- Fragmented system

Goal

Create a new patient care model to better serve patients with chronic medical conditions

AIMS

- Empower patients to take more responsibility for their medical conditions
- Patients are assigned a local medical home
- Improve coordination and communication among providers at all levels

Solution

- Develop an integrated Network to better coordinate care
- Establish ongoing communication links amongst providers
- Introduce Community Health Specialist-coach and care manage
- Track and communicate progress among providers
- Establish a personal health record

Key Components

- Identify at-risk, uninsured, chronically ill, hospital patients
- Partner with 3 CHC's and 5 PPP's
- Train Community Health Specialist to coach and mentor patients on AIMS
- Leverage web-based technology (NaviLinx) to monitor and communicate vital health care information

Benefits

- Better care management
- Created an integrated Network centered around local primary care homes
- Patients take responsibility for managing their medical conditions
- Coach and empower frequent users to navigate our fragmented health care Network
- Improve health care outcomes
- Cost effective
- Foster better communication and hand-off among providers

Added Value Benefits for Providers

- Collegial relationships and improved communication
- Ability to access vital patient information
- Mini fellowships
- Specialty care referral phone consults